North Carolina Department of Health and Human Services
Michael F. Easley, Governor Dempsey Benton, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Michael Moseley, Director

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100• Fax 919-733-6608
William W. Lawrence, Jr., MD, Acting Director

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MEMORANDUM

TO: Legislative Oversight Committee Members; Local CFAC Chairs; NC Council of Community Programs; County Managers; State Facility Directors; LME Board Chairs; Advocacy Organizations; MH/DD/SAS Stakeholder Organizations; Commission for MH/DD/SAS; State CFAC; NC Assoc. of County Commissioners; County Board Chairs; LME Directors; DHHS Division Directors; Provider Organizations; NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD

Mike Moseley

SUBJECT: Implementation Update #36: Changes to Implementation Updates, Community Support Service, Comprehensive Clinical Assessment, Training and CAP-MR/DD Endorsement

New Approach to Implementation Updates

The Divisions of Medical Assistance and Mental Health, Developmental Disabilities, and Substance Abuse Services have been issuing joint memoranda labeled as "Implementation Updates" since January, 2006. Although we have received a lot of positive feedback on this communication series, we have also heard that since the Implementation Updates have not come out at regular, preset intervals it can be difficult to know when to check for new or updated information. We appreciate this concern and have decided that as a general rule, we will standardize the issuance of Implementation Updates on the first Monday of each month. This routine publication date should assist Local Management Entities, providers, consumers and families and other stakeholders in accessing this important information and will help the better manage the pace of change. We will only deviate from this schedule in the event that we must communicate some unanticipated, time-sensitive information.

Revised Community Support Definition

Over the past several months, there have been many activities occurring regarding the Community Support service and its impact on the rest of the mh/dd/sa community services. In addition to all the clinical post payment reviews, DMA and DMH/DD/SAS conducted seven (7) Access to Care Training Sessions which clarified the role of Clinical Home, provided more understanding of person centered thinking, modified the period during which Community Support could be delivered without prior authorization, and introduced the role of a Comprehensive Clinical Assessment. The information gathered and reviewed during post payment reviews, the questions and comments received during the Access to Care Training, the review of all the utilization and billing patterns of community support and other mh/dd/sa services, in addition to legislative mandates required in by the General Assembly in Session Law 2007-323, Section 10.49 (ee), are the basis of the revised Child and Adult Community Support

Service changes. The proposed changes to the Community Support definitions for adults and children/adolescents in Clinical Coverage Policy 8A, Enhanced Mental Health and Substance Abuse Services, have been posted for public comment at http://www.ncdhhs.gov/dma/mp/proposedmp.htm. The posting includes "track change" and "reading" copies as well as a summary of changes made to the definitions and the purpose for each change. Comments will be accepted through December 11, 2007 at dma.webmedpolicy@ncmail.net. The target date for implementation of the revised definition is January 1, 2008.

Community Support Billing Changes

As required by Session Law 2007-323, Section 10.49 (ee), effective December 1, 2007, Community Support Services billed with date of service effective December 1, 2007 will require additional modifiers to identify units of service provided by the Qualified Professional (QP) and the Non-Qualified Professional (non-QP) staff persons. Community Intervention Services (CIS) providers with provider type 112 and Specialties 116 and 118 will be required to bill a secondary modifier on the claim submission for:

H0036 HA – Community Support Child
H0036 HB – Community Support Adult
H0036 HQ – Community Support Group

The identified modifiers for use are as follows:

Modifier U3 will be used as the secondary modifier to identify a service rendered by a Qualified Professional (QP).

Modifier U4 will be used as a secondary modifier to identify a service rendered by a non-Qualified Professional (non-QP).

CMS-1500 Claim Examples:

These examples are for illustration purposes only. Actual codes billed should reflect who rendered the services.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12	01	07	12	01	07	11		H0036	HA U3		256.40	20		1D NPI	555555B NPI Number
1 12	01	07	12	01	07	11		H0036	HA U4		256.40	20		1D NPI	555555B NPI Number

Refer to the November, 2007 Medicaid Bulletin for further guidance and information regarding the use of the modifiers.

Billing for Community Support Services

When DMA or a Local Management Entity (LME) sanctions a provider through actions such as withdrawing endorsement, terminating a provider number, placing a provider on suspension or placing the provider on payment withhold, the provider may **not** shift billing to another provider number or request another provider to bill on their behalf. Authorization and billing is assigned to a specific provider number, is site specific and is predicated on the assumption that the site is responsible for the delivery and accountability of the services rendered and billed. These kinds of "alternative" billing actions will be considered acts of fraud since they seek to avoid the prescribed sanctions. Any such activity will be referred for investigation and constitutes a violation of the DMA provider enrollment agreement, on the part of both the provider seeking to avoid the sanctions and any other provider that may be involved in the alternative billing scheme.

Comprehensive Clinical Assessment

We have received numerous questions about the function and requirements for a comprehensive clinical assessment in person centered planning. A "comprehensive clinical assessment" is not a service definition; rather it is an intensive clinical and functional face-to-face evaluation of an individual's presenting mental health, developmental disability, and/or substance abuse condition that results in the issuance of a written report, providing the clinical basis for the development of the Introductory Person Centered Plan (PCP), the Complete PCP, or the service plan

when a PCP is not required. This written report also includes recommendations for services, supports, and/or treatment. Through a comprehensive clinical assessment, the information essential to formulating a diagnosis and plan of treatment is gathered.

A comprehensive assessment can be billed through a variety of evaluation and assessment procedure codes including, but not limited to:

Diagnostic Assessment (performed according to the service definition): T1023
Evaluation/Intake: 90801, 90802
Assessment: H0001, H0031
Evaluation & Management (E/M) Codes
State Substance Abuse Assessment: YP830 (not Medicaid billable)

The elements listed below for a comprehensive clinical assessment are accepted by our Divisions as meeting the standards for an initial professional assessment. The purpose of the comprehensive clinical assessment is to provide the Qualified Professional with the necessary data and recommendations to perform the analysis and synthesis of this information in the development of the PCP with the consumer. A comprehensive clinical assessment offers an opinion as to whether the consumer is appropriate for and can benefit from mental health, developmental disabilities, and/or substance abuse services. It also evaluates the consumer's level of readiness and motivation to engage in treatment and, for individuals with substance abuse conditions, recommends a level of placement using the American Society of Addiction Medicine (ASAM) Criteria. For individuals with developmental disabilities it provides a basis for identifying the comprehensive service and support needs of the consumer.

For some individuals being evaluated for membership in a target population (applicable to state-funded consumers only), certain diagnostic tools specified by DMH/DD/SAS must also be utilized and become a part of the data used to develop the PCP. For example, the SUDDS-IV, ASI, or SASSI-3 are required for specific substance abuse target populations, or intellectual and adaptive functioning assessments are required for persons with developmental disabilities. In these cases, the Qualified Professional completing the PCP may be analyzing the report from the professional who performed the comprehensive clinical assessment as well as the report from the psychologist who completed the psychological testing. The Service Records Manual (http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm_serv-record-manual-10-07.pdf) provides a detailed discussion of service-specific assessment tools. For such specialized tests to be considered a comprehensive clinical assessment, the report must contain all the elements listed below.

An assessment completed at a State Operated Facility can fulfill the requirements of a comprehensive clinical assessment if it contains all of the required elements. If there have been changes in the clinical presentation of the consumer since the completion of the State Operated Facility's assessment, an additional assessment may be needed.

The format of a comprehensive clinical assessment is determined by the individual provider based on the clinical presentation. Although a comprehensive clinical assessment does not have a designated format, the assessment (or collective assessments) used must include the following elements:

A. a chronological general health and behavioral health history (including mental health and substance abuse) of the consumer's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;

B. biological, psychological, familial, social, developmental and environmental dimensions which identifies strengths, weaknesses, risks, and protective factors in each area;

C. a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;

D. a strengths/protective factors/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment (MH/SA), and treatment and recovery history (MH/SA);

E. a strengths-based assessment that identifies the consumer/family functional strengths including natural and informal supports, preferences, needs, and cultural diversity issues;

F. evidence of consumer/legally responsible person's participation in the assessment;

G. recommendation regarding target population eligibility (state-funded services only);

H. an analysis and interpretation of the assessment information with an appropriate case formulation;

I. diagnoses on all five (5) axes of DSM-IV; and

J. recommendations for additional assessments, services, support, or treatment based on the results of the comprehensive clinical assessment.

Appendix a gives further detail about how a comprehensive clinical assessment may be tailored to best meet the needs of the population served.

Training

In July 2006, we communicated through Implementation Update # 10 the courses required to satisfy the training requirements for the service definitions. The training requirements for Community Support, Mobile Crisis and Intensive In-Home Services have indicated that the training must be delivered by "DMH/DD/SAS endorsed trainers." Similarly, Assertive Community Treatment Team (ACTT) has required training be received from the Evidenced Based Practices Center of Southeastern AHEC. After careful thought and analysis, we have removed these requirements as well as the requirement for trainers to hold a master's degree or higher in order to provide the training. The specific training requirements for each service definition are outlined in ***Appendix B***.

It is our belief that implementing these changes will allow greater flexibility within provider agencies to train staff and build internal capacity, as well as offer better access to trainers. While the requirement to have training delivered by endorsed trainers has been eliminated, the service definition specific training must still be delivered based upon the minimal required training elements approved by our Divisions. DMH/DD/SAS has developed and implemented a clinical skills training web page (www.ncdhhs.gov/mhddsas). On this web page are the required training elements for Community Support, Mobile Crisis and Intensive In-Home Services, along with pre and post tests and evaluation templates. These elements are to be used to develop the full training curricula to meet the hourly requirements for each service definition. Providers may choose to develop their own curriculum to develop internal capacity but the curriculum must be based on the minimal required training elements posted on the web page listed above. The information necessary to offer ACTT training from the SAMHSA ACTT Toolkit and the NAMI PACT Manual also is included on this website.

Additionally, listed on the website is information on the trainers who had previously been endorsed to provide these trainings. We encourage but will not require providers to use formerly endorsed trainers, the Behavioral Healthcare Resource Program at the UNC School of Social Work, the NC Evidence Based Practice Center at Southern Regional AHEC, and other entities with previous experience in training for these services to conduct "train the trainer" classes for any other trainers that the provider may choose use to train their staff in the future.

Provider agencies will continue to have responsibility for maintaining documentation to verify that staff has completed the required training. All staff that provide services must receive required training in accordance with the timeframes outlined in the service definition or within 90 days of employment, which ever occurs first. Individual staff who deliver multiple services only need to take a course that may be required for by multiple service definitions only one time to fulfill the requisites for all definitions. For example, a person who provides both Community Support and Community Support Team need only take one 6 hour Person Centered Thinking course to fulfill the 6 hour requirement for each definition. The service definition specific training must be taken for each service the individual delivers. Training required for other purposes – such as NCI, CPR, first aid – may not be counted toward any of the optional training hours outlined in the attachment. Up to three hours of optional training may be delivered via web-based learning programs if the web-based training includes a post-test to verify understanding of the materials and the program provides documentation of completion. Documentation of completion consists of a certificate of completion indicating the name and date of the training and name of trainer

along with the number of contact hours received. The individual who received the training should have his or her name on the certificate and a copy of the certificate should be retained in the personnel file for inspection during audits.

DMH/DD/SAS has developed a dedicated an email address to receive questions regarding training. Please email DMH.training@ncmail.net with all questions regarding service definition training.

CAP-MR/DD Endorsement Clarification

There have been a number of questions regarding the application of Implementation Update #33: Full Endorsement of Providers to providers of CAP-MR/DD services. We hope the following clarification is helpful:

- CAP-MR/DD providers that were enrolled with DMA to provide CAP-MR/DD services prior to the August 1, 2006 CAP-MR/DD "endorsement window" will not be required to complete the full endorsement process. These providers were required to sign the Memorandum of Agreement (MOA) and provide proof of insurance during the transition to endorsement.
- Providers that were enrolled to provide CAP-MR/DD services between August 1, 2006 and October 1, 2007 were also required to sign the MOA and provide proof of insurance. No additional action is necessary by these providers.
- Any provider that was not enrolled with DMA to provide CAP-MR/DD services on or before October 1, 2007 must complete the endorsement process in accordance with the procedures outlined in the Provider Endorsement Policy, section #10, CAP-MR/DD.
- Any CAP-MR/DD provider that wishes to add a new service to their enrollment must be reviewed against the service definition check sheet in order to have that service added to the list of CAP-MR/DD services they are authorized to provide.

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Please contact us at ContactDMH@ncmail.net if you have questions regarding this Implementation Update.

Appendices

cc: Secretary Dempsey Benton
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Christina Carter
Marcia Copeland
Sharnese Ransome
Kaye Holder
Wayne Williams
Kory Goldsmith
Andrea Poole
Mark Van Sciver
Brad Deen

Appendix A

Comprehensive Clinical Assessment by Population

The guidance below is specific to the consumer population being served.

Services for Children

In the case of children/youth and their families, the comprehensive clinical assessment should:

- address the prior existence and work of the Child and Family Team (CFT).
- if the family is new to services, recommend members of the Child and Family Team that the family and Qualified Professional will convene.
- assess the strengths of the child/youth and their family. Consider utilizing a strength-based assessment tool. For more information on Strength-Based Assessments go to: http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm
- utilize information such as reports from psychological testing and/or Individualized Education Plans.

Recommendations for services from the comprehensive clinical assessment are considered by the CFT for person-centered planning. The assessment of strengths provides necessary information from which the Child and Family Team can begin their work.

Adult Mental Health

For all adults with a diagnosis of a major mental illness, the assessment should identify the clinical services appropriate to treat the diagnosed condition. The assessment should incorporate principles of education, wellness and recovery, empowerment in developing an inter-dependent partnership with the consumer during the diagnostic process. The assessment should also identify whether there is a need for additional evaluations such as psychological testing, psychiatric evaluation, medication evaluation, or additional assessments to identify potential co-occurring diagnoses. Upon the completion of the comprehensive clinical assessment process, the clinical practitioner(s) should work directly with the clinical home provider in the development of the PCP for services, natural supports, and crisis prevention activities all related to wellness management.

Developmental Disabilities Services

A comprehensive clinical assessment supports the person centered planning process for individuals with developmental disabilities. In many cases, persons with a developmental disability have multiple disabilities and present with complex profiles that necessitate a more comprehensive approach to addressing their needs. Since developmental disabilities are life long conditions, the focus of the comprehensive clinical assessment is on identifying the person's current functioning status and identifying needed supports to help the person achieve and maintain maximum independence. Such an approach often requires a variety of clinical assessments (e.g., intellectual assessment, psychiatric assessment, physical evaluation, educational/vocational assessment, PT/OT evaluation). It should also be noted that the assessment is not a one-time event. A person with a developmental disability may require periodic assessments to determine their ongoing needs.

Substance Abuse Services

The information gathered in the comprehensive clinical assessment should be utilized to determine the appropriate level of care using the ASAM Patient Placement -2 as a clinical guide. The ASAM level of care recommendation should be included in the disposition of the comprehensive clinical assessment.

Appendix B

Service Definitions Training Requirements

Service Definition	Requirement in Service Definition	Courses Which Satisfy Training Requirements
Community Support – Adults and Children/Adolescents (MH/SA)	20 hours to include service definition-specific and crisis response.	▪ 6 hours service definition training ▪ 3 hours – crisis response ▪ 6 hours Person Centered Thinking ▪ QP staff responsible for PCP development: 3 hours – "PCP Instructional Elements." ▪ 2-5 hours in other topics related to service and population(s) being served
Community Support Team (CST) (MH/SA)	20 hours including service definition-specific and crisis management.	▪ 6 hours service definition training ▪ 3 hours – crisis response ▪ 6 hours Person Centered Thinking ▪ QP staff responsible for PCP development: 3 hours – "PCP Instructional Elements." ▪ 2-5 hours in other topics related to service and population(s) being served
Mobile Crisis Management (MH/DD/SA)	20 hours in appropriate crisis intervention strategies.	▪ 6 hours service definition training ▪ 6 hours Person Centered Thinking ▪ 8 hours in other content areas to achieve twenty hours of training in crisis intervention strategies. First Responder Crisis Toolkit training is highly recommended. ▪ http://behavioralhealthcareinstitute.org/
Intensive In-Home Services	"…the intensive training."	▪ 12 hours service definition training ▪ 6 hours Person Centered Thinking ▪ 3 hours – "PCP Instructional Elements." ▪ 2-5 hours in other content areas related to children/adolescents. Crisis response training is highly recommended.
Assertive Community Treatment Team (ACTT). Also Toolkit	This will be defined as the choices outlined in the Implementation Update # (?) and as described on DHM/DD/SA training web page.	▪ DMH/DD/SAS approved service definition specific training. ▪ http://www.ncebpcenter.org/home.htm ▪ 6 hours Person Centered Thinking ▪ QP staff responsible for PCP development: 3 hours – "PCP Instructional Elements." ▪ Additional training in other content options is encouraged.
Substance Abuse Intensive Outpatient Program		▪ 6 hours Person Centered Thinking ▪ QP staff responsible for PCP development: 3 hours – "PCP Instructional Elements." ▪ Additional training in other content options congruent with the goals of ASAM is encouraged.
Substance Abuse Comprehensive Outpatient Treatment Program		▪ 6 hours Person Centered Thinking ▪ QP staff responsible for PCP development: 3 hours – "PCP Instructional Elements." ▪ Additional training in other content options congruent with the goals of ASAM is encouraged.
Diagnostic/Assessment (MH/DD/SA)		▪ 6 hours Person Centered Thinking. Highly recommended: 6 hours service definition training
	Requirement in Service	**Courses Which Satisfy Training Requirements**

Service Definition	Definition	
Multi-Systemic Therapy (MST)	MST required training	▪ MST specific required training: MST introductory training, quarterly training; minimum of one (1) hour of group supervision and one (1) hour of phone consultation per week. ▪ 6 hours Person Centered Thinking ▪ QP staff responsible for PCP development: 3 hours – "PCP Instructional Elements."
Psychosocial Rehabilitation		▪ 6 hours Person Centered Thinking
Child and Adolescent Day Treatment (MH/SA)		▪ 6 hours Person Centered Thinking ▪ QP staff responsible for PCP development: 3 hours – "PCP Instructional Elements."
Partial Hospitalization		▪ 6 hours Person Centered Thinking
Professional Treatment Services in Facility-Based Crisis Programs		▪ 6 hours Person Centered Thinking
Non-Medical Community Residential Treatment		▪ 6 hours Person Centered Thinking ▪ Highly recommended: 6 hour training covering all substance abuse residential service definitions
Medically Monitored Community Residential Treatment		▪ 6 hours Person Centered Thinking ▪ Highly recommended: 6 hour training covering all substance abuse residential service definitions
Medically Supervised or ADATC Detoxification/Crisis Stabilization		▪ 6 hours Person Centered Thinking ▪ Highly recommended: 6 hour training covering all substance abuse residential service definitions
Ambulatory Detoxification		▪ 6 hours Person Centered Thinking ▪ Highly recommended: 6 hour training covering all substance abuse residential service definitions
Social Setting Detoxification		▪ 6 hours Person Centered Thinking ▪ Highly recommended: 6 hour training covering all substance abuse residential service definitions
Non-Hospital Medical Detoxification		▪ 6 hours Person Centered Thinking ▪ Highly recommended: 6 hour training covering all substance abuse residential service definitions
Targeted Case Management for DD		▪ 6 hours Person Centered Thinking ▪ 3 hours – "PCP Instructional Elements